MEDICAID-MCO SUBROGATION

Eashaan Vajpeyi
Partner-Attorney
www.ballkirkholm.com

BALL, KIRK & HOLM, P.C.
ATTORNEYS AT LAW

SCOPE OF PRESENTATION

* General background on new code section

* Personal interpretations based on experience dealing with MCOs and the "paranoid" perspective

* Open dialogue re: how insurers; def. attorneys; and pl. attorneys can get on the "same page"

BACKGROUND

- Medicaid privatization in 2016-why now?
  - 2016: MCOs struggling with the basics; many Medicaid recipients still with Fee for Service or the "Department"
  - 2016-2020: MCOs are dropping in and out of the market; MCOs aren't being repaid
  - 2019: GAO report that CMS is not ensuring state plan compliance
  - 2023: New MCO contracts; stability in the MCOs lets them focus on chasing TPL? ; new focus on complying with federal law to ensure federal funding

BACKGROUND

- 2022 Legislative Session
  - A copy / paste job from another state’s code surfaces from DHS and the MCOs
  - IAJ engages to make it as good as possible
    - Frequently told “required by federal law”; was hard to verify in the moment
  - A lot of federal money on the line

§ 249A.54 EFFECTIVE JULY 1, 2023

- Attempts to define the scope of repayment from third-party benefits to Medicaid payors, who is liable for the repayment, and the requirements on recipients to cooperate
  - Scope: Reimbursement for any payments by the Medicaid payor for medical expenses for which a third party is, may be, could be, should be, or has been liable
    - If third party benefits are discovered or become available after assistance has been provided, it is the intent that the Medicaid payor is repaid in full.
  - Liable parties: A release or satisfaction of any cause of action shall not be effective against a lien unless the Medicaid payor joins.
    - Global releases; Date of submission to Commissioner; Payments on settlement or decisions
  - Cooperation: Multiple different notice requirements for recipients and their agents staggered throughout course of representation

KEY DEFINITIONS

- "Medicaid payor" (MP) = the department & anyone else including MCOs. 249A.54(2)(c)
- MP is repaid in full from "third-party benefits" 249A.54(1)
- "Third-party benefits" = any benefits which are or may be available that provide or pay for medical. Incl. benefits from: causes of action and their proceeds; liability, UI/UIM, PIP; *medical benefits* under WC; benefits from any obligation to provide *medical support.* 249A.54(2)(j)

KEY DEFINITIONS

- “Recipient”=applied for or has received assistance 249A.54(2)(g)
- “Recipient’s agent” incl. legal guardian; legal rep., or anyone acting on their behalf 249A.54(2)(h)
- “Third party” = is or may be liable to pay medical bills for a recipient, incl. TPA; hlth. Insurer; self-insured; liability, no fault ins. “workers’ compensation laws or plans” 249A.54(2)(i)

MEDICAID PAYOR RIGHTS

- When the MP pays, their rights include the following and are construed together to provide the greatest recovery of TPB:
  - Automatically subrogated to any rights to a TPB for the full amount; no equities 249A.54(8)(a); *c.f.* 249A.54(16) on reductions for fees
    - Recovery not limited to a portion of judgment, award, or settlement but full recovery from any and all **third-party benefits**. 249A.54(8)(a);
  - Automatic lien upon the cause of action. 249A.54(8)(c)
    - May recover damages against the person accepting the release or satisfaction or the person making the settlement. 249A.54(8)(c)(5)
  - May collect recovered benefits directly from a third party, the recipient, a medical provider, any person who has received the third-party benefit. 249A.54(9)

PLAINTIFF OBLIGATIONS

- Many notice requirements
  - Notice of awareness / Notice of initiating recovery
    - Includes all information on possible third parties
  - Notice of action
  - Notice of settlement
    - Failure to give notice prior to finalizing judgment, award, settlement or other recovery = atty. joint and several liability for the claimed amount. 249A.54(14)
  - Notice of dismissal
- Cooperation
  - Includes paying to the Medicaid payor any third-party benefit received. 249A.54(10)(a)(4)
  - Refusal to cooperate may lead to denial or termination of eligibility. 249A.54(10)(c)

WORK COMP APPLICABILITY

- Accepted claims
  - No payments from MP should be made
- Denied, then accepted
  - Any payments from MP should be reimbursed by WC
- Denied, settled
  - What is the consideration paid? *Rich v. Dyna Technology, Inc., 204 N.W.2d 867 (Iowa 1973).*
- Global releases
  - Can’t accept / execute without considering MP
- Unauthorized care

WORK COMP APPLICABILITY

"Third-party benefits" mean any **benefits that are or may be available to a recipient from a third party and that provide or pay for medical services.** "Third-party benefits" may be created by law, contract, court award, judgment, settlement, agreement, or any arrangement between a third party and any person or entity, recipient, or otherwise. "Third-party benefits" **include but are not limited to all of the following**:

(1) Benefits from collateral (any and all causes of action related to a covered injury or illness requiring medical assistance or judgements or settlements on such causes of action) or proceeds.
(2) Health insurance benefits.
(3) Health maintenance organization benefits.
(4) Benefits from preferred provider arrangements and prepaid health clinics.
(5) Benefits from liability insurance, uninsured and underinsured motorist insurance, or personal injury protection coverage.
(6) Medical benefits under workers' compensation.
(7) Benefits from any obligation under law or equity to provide medical support.

QUESTIONS-CONTACT INFO

www.ballkirkholm.com

evajpeyi@ballkirkholm.com

Iowa Code § 249A.54

This document is current through legislation from the 2023 Regular Session of the 90th General Assembly, with the exception of HF143, HF430, HF471, HF475, HF655, HF670, and SF514.

LexisNexis® Iowa Annotated Statutes > Title VI Human Services (Subts. 1 — 6) > Subtitle 6 Children and Families (Chs. 234 — 255A) > Chapter 249A Medical Assistance (Subchs. I — II) > Subchapter II Medical Assistance Program Integrity (§§ 249A.39 — 249A.59)

249A.54 Responsibility for payment on behalf of Medicaid-eligible persons — liability of other parties.

1. It is the intent of the general assembly that a Medicaid payor be the payor of last resort for medical services furnished to recipients. All other sources of payment for medical services are primary relative to medical assistance provided by the Medicaid payor. If benefits of a third party are discovered or become available after medical assistance has been provided by the Medicaid payor, it is the intent of the general assembly that the Medicaid payor be repaid in full and prior to any other person, program, or entity. The Medicaid payor shall be repaid in full from and to the extent of any third-party benefits, regardless of whether a recipient is made whole or other creditors are paid.

2. For the purposes of this section:

a. "Collateral" means all of the following:

(1) Any and all causes of action, suits, claims, counterclaims, and demands that accrue to the recipient or to the recipient's agent, related to any covered injury or illness, or medical services that necessitated that the Medicaid payor provide medical assistance to the recipient.

(2) All judgments, settlements, and settlement agreements rendered or entered into and related to such causes of action, suits, claims, counterclaims, demands, or judgments.

(3) Proceeds.

b. "Covered injury or illness" means any sickness, injury, disease, disability, deformity, abnormality disease, necessary medical care, pregnancy, or death for which a third party is, may be,

could be, should be, or has been liable, and for which the Medicaid payor is, or may be, obligated to provide, or has provided, medical assistance.

c. "Medicaid payor" means the department or any person, entity, or organization that is legally responsible by contract, statute, or agreement to pay claims for medical assistance including but not limited to managed care organizations and other entities that contract with the state to provide medical assistance under chapter 249A.

d. "Medical service" means medical or medically related institutional or noninstitutional care, or a medical or medically related institutional or noninstitutional good, item, or service covered by Medicaid.

e. "Payment" as it relates to third-party benefits, means performance of a duty, promise, or obligation, or discharge of a debt or liability, by the delivery, provision, or transfer of third-party benefits for medical services. "To pay" means to make payment.

f. "Proceeds" means whatever is received upon the sale, exchange, collection, or other disposition of the collateral or proceeds from the collateral and includes insurance payable because of loss or damage to the collateral or proceeds. "Cash proceeds" include money, checks, and deposit accounts and similar proceeds. All other proceeds are "noncash proceeds".

g. "Recipient" means a person who has applied for medical assistance or who has received medical assistance.

h. "Recipient's agent" includes a recipient's legal guardian, legal representative, or any other person acting on behalf of the recipient.

i. "Third party" means an individual, entity, or program, excluding Medicaid, that is or may be liable to pay all or a part of the expenditures for medical assistance provided by a Medicaid payor to the recipient. A third party includes but is not limited to all of the following:

(1) A third-party administrator.

(2) A pharmacy benefits manager.

(3) A health insurer.

(4) A self-insured plan.

(5) A group health plan, as defined in section 607(1) of the federal Employee Retirement Income Security Act of 1974.

(6) A service benefit plan.

(7) A managed care organization.

(8) Liability insurance including self-insurance.

(9) No-fault insurance.

(10) Workers' compensation laws or plans.

(11) Other parties that by law, contract, or agreement are legally responsible for payment of a claim for medical services.

j. "Third-party benefits" mean any benefits that are or may be available to a recipient from a third party and that provide or pay for medical services. "Third-party benefits" may be created by law, contract, court award, judgment, settlement, agreement, or any arrangement between a third party and any person or entity, recipient, or otherwise. "Third-party benefits" include but are not limited to all of the following:

(1) Benefits from collateral or proceeds.

(2) Health insurance benefits.

(3) Health maintenance organization benefits.

(4) Benefits from preferred provider arrangements and prepaid health clinics.

(5) Benefits from liability insurance, uninsured and underinsured motorist insurance, or personal injury protection coverage.

(6) Medical benefits under workers' compensation.

(7) Benefits from any obligation under law or equity to provide medical support.

3. Third-party benefits for medical services shall be primary to medical assistance provided by the Medicaid payor.

4.

a. A Medicaid payor has all of the rights, privileges, and responsibilities identified under this section. Each Medicaid payor is a Medicaid payor to the extent of the medical assistance provided by that Medicaid payor. Therefore, Medicaid payors may exercise their Medicaid payor's rights under this section concurrently.

b. Notwithstanding the provisions of this subsection to the contrary, if the department determines that a Medicaid payor has not taken reasonable steps within a reasonable time to recover third-party benefits, the department may exercise all of the rights of the Medicaid payor under this section to the exclusion of the Medicaid payor. If the department determines the department will exercise such rights, the department shall give notice to third parties and to the Medicaid payor.

5. A Medicaid payor may assign the Medicaid payor's rights under this section, including but not limited to an assignment to another Medicaid payor, a provider, or a contractor.

6. After the Medicaid payor has provided medical assistance under the Medicaid program, the Medicaid payor shall seek reimbursement for third-party benefits to the extent of the Medicaid payor's legal liability and for the full amount of the third-party benefits, but not in excess of the amount of medical assistance provided by the Medicaid payor.

7. On or before the thirtieth day following discovery by a recipient of potential third-party benefits, a recipient or the recipient's agent, as applicable, shall inform the Medicaid payor of any rights the recipient has to third-party benefits and of the name and address of any person that is or may be liable to provide third-party benefits.

8. When the Medicaid payor provides or becomes liable for medical assistance, the Medicaid payor has the following rights which shall be construed together to provide the greatest recovery of third-party benefits:

a. The Medicaid payor is automatically subrogated to any rights that a recipient or a recipient's agent or legally liable relative has to any third-party benefit for the full amount of medical assistance provided by the Medicaid payor. Recovery pursuant to these subrogation rights shall not be reduced, prorated, or applied to only a portion of a judgment, award, or settlement, but shall provide full recovery to the Medicaid payor from any and all third-party benefits. Equities of a recipient or a recipient's agent, creditor, or health care provider shall not defeat, reduce, or prorate recovery by the Medicaid payor as to the Medicaid payor's subrogation rights granted under this paragraph.

b. By applying for, accepting, or accepting the benefit of medical assistance, a recipient or a recipient's agent or legally liable relative automatically assigns to the Medicaid payor any right, title, and interest such person has to any third-party benefit, excluding any Medicare benefit to the extent required to be excluded by federal law.

(1) The assignment granted under this paragraph is absolute and vests legal and equitable title to any such right in the Medicaid payor, but not in excess of the amount of medical assistance provided by the Medicaid payor.

(2) The Medicaid payor is a bona fide assignee for value in the assigned right, title, or interest and takes vested legal and equitable title free and clear of latent equities in a third party. Equities of a recipient or a recipient's agent, creditor, or health care provider shall not defeat or reduce recovery by the Medicaid payor as to the assignment granted under this paragraph.

c. The Medicaid payor is entitled to and has an automatic lien upon the collateral for the full amount of medical assistance provided by the Medicaid payor to or on behalf of the recipient for medical services furnished as a result of any covered injury or illness for which a third party is or may be liable.

(1) The lien attaches automatically when a recipient first receives medical services for which the Medicaid payor may be obligated to provide medical assistance.

(2) The filing of the notice of lien with the clerk of the district court in the county in which the recipient's eligibility is established pursuant to this section shall be notice of the lien to all persons. Notice is effective as of the date of filing of the notice of lien.

(3) If the Medicaid payor has actual knowledge that the recipient is represented by an attorney, the Medicaid payor shall provide the attorney with a copy of the notice of lien. However, this provision of a copy of the notice of lien to the recipient's attorney does not abrogate the attachment, perfection, and notice satisfaction requirements specified under subparagraphs (1) and (2).

(4) Only one claim of lien need be filed to provide notice and shall provide sufficient notice as to any additional or after-paid amount of medical assistance provided by the Medicaid payor for any specific covered injury or illness. The Medicaid payor may, in the Medicaid payor's discretion, file additional, amended, or substitute notices of lien at any time after the initial filing until the Medicaid payor has been repaid the full amount of medical assistance provided by Medicaid or otherwise has released the liable parties and recipient.

(5) A release or satisfaction of any cause of action, suit, claim, counterclaim, demand, judgment, settlement, or settlement agreement shall not be effective as against a lien created under this paragraph, unless the Medicaid payor joins in the release or satisfaction or executes a release of the lien. An acceptance of a release or satisfaction of any cause of action, suit, claim, counterclaim, demand, or judgment and any settlement of any of the foregoing in the absence of a release or satisfaction of a lien created under this paragraph shall prima facie constitute an impairment of the lien, and the Medicaid payor is entitled to recover damages on account of such impairment. In an action on account of impairment of a lien, the Medicaid payor may recover from the person accepting the release or satisfaction or the person making the settlement the full amount of medical assistance provided by the Medicaid payor.

(6) The lack of a properly filed claim of lien shall not affect the Medicaid payor's assignment or subrogation rights provided in this subsection nor affect the existence of the lien, but shall only affect the effective date of notice.

(7) The lien created by this paragraph is a first lien and superior to the liens and charges of any provider of a recipient's medical services. If the lien is recorded, the lien shall exist for a period of seven years after the date of recording. If the lien is not recorded, the lien shall exist for a period of seven years after the date of attachment. If recorded, the lien may be extended for one additional period of seven years by rerecording the claim of lien within the ninety-day period preceding the expiration of the lien.

9. Except as otherwise provided in this section, the Medicaid payor shall recover the full amount of all medical assistance provided by the Medicaid payor on behalf of the recipient to the full extent of third-party benefits. The Medicaid payor may collect recovered benefits directly from any of the following:

a. A third party.

b. The recipient.

c. The provider of a recipient's medical services if third-party benefits have been recovered by the provider. Notwithstanding any provision of this section to the contrary, a provider shall not be required to refund or pay to the Medicaid payor any amount in excess of the actual third-party benefits received by the provider from a third party for medical services provided to the recipient.

d. Any person who has received the third-party benefits.

10.

a. A recipient and the recipient's agent shall cooperate in the Medicaid payor's recovery of the recipient's third-party benefits and in establishing paternity and support of a recipient child born out of wedlock. Such cooperation shall include but is not limited to all of the following:

(1) Appearing at an office designated by the Medicaid payor to provide relevant information or evidence.

(2) Appearing as a witness at a court proceeding or other legal or administrative proceeding.

(3) Providing information or attesting to lack of information under penalty of perjury.

(4) Paying to the Medicaid payor any third-party benefit received.

(5) Taking any additional steps to assist in establishing paternity or securing third-party benefits, or both.

b. Notwithstanding paragraph "a", the Medicaid payor has the discretion to waive, in writing, the requirement of cooperation for good cause shown and as required by federal law.

c. The department may deny or terminate eligibility for any recipient who refuses to cooperate as required under this subsection unless the department has waived cooperation as provided under this subsection.

11. On or before the thirtieth day following the initiation of a formal or informal recovery, other than by filing a lawsuit, a recipient's attorney shall provide written notice of the activity or action to the Medicaid payor.

12. A recipient is deemed to have authorized the Medicaid payor to obtain and release medical information and other records with respect to the recipient's medical services for the sole purpose of obtaining reimbursement for medical assistance provided by the Medicaid payor.

13.

a. To enforce the Medicaid payor's rights under this section, the Medicaid payor may, as a matter of right, institute, intervene in, or join in any legal or administrative proceeding in the Medicaid payor's own name, and in any or a combination of any, of the following capacities:

(1) Individually.

(2) As a subrogee of the recipient.

(3) As an assignee of the recipient.

(4) As a lienholder of the collateral.

b. An action by the Medicaid payor to recover damages in an action in tort under this subsection, which action is derivative of the rights of the recipient, shall not constitute a waiver of sovereign immunity.

c. A Medicaid payor, other than the department, shall obtain the written consent of the department before the Medicaid payor files a derivative legal action on behalf of a recipient.

d. When a Medicaid payor brings a derivative legal action on behalf of a recipient, the Medicaid payor shall provide written notice no later than thirty days after filing the action to the recipient, the recipient's agent, and, if the Medicaid payor has actual knowledge that the recipient is represented by an attorney, to the attorney of the recipient, as applicable.

e. If the recipient or a recipient's agent brings an action against a third party, on or before the thirtieth day following the filing of the action, the recipient, the recipient's agent, or the attorney of the recipient or the recipient's agent, as applicable, shall provide written notice to the Medicaid payor of the action, including the name of the court in which the action is brought, the case number of the action, and a copy of the pleadings. The recipient, the recipient's agent, or the attorney of the recipient or the recipient's agent, as applicable, shall provide written notice of intent to dismiss the action at least twenty-one days before the voluntary dismissal of an action against a third party. Notice to the Medicaid payor shall be sent as specified by rule.

14. On or before the thirtieth day before the recipient finalizes a judgment, award, settlement, or any other recovery where the Medicaid payor has the right to recovery, the recipient, the recipient's agent, or the attorney of the recipient or recipient's agent, as applicable, shall give the Medicaid payor notice of the judgment, award, settlement, or recovery. The judgment, award, settlement, or recovery shall not be finalized unless such notice is provided and the Medicaid payor has had a reasonable opportunity to recover under the Medicaid payor's rights to subrogation, assignment, and lien. If the Medicaid payor is not given notice, the recipient, the recipient's agent, and the recipient's or recipient's agent's attorney are jointly and severally liable to reimburse the Medicaid payor for the recovery received to the extent of medical assistance paid by the Medicaid payor. The notice required under this subsection means written notice sent via certified mail to the address listed on the department's internet site for a Medicaid payor's third-party liability contact. The notice requirement is only satisfied for the specific Medicaid payor upon receipt by the specific Medicaid payor's third-party liability contact of such written notice sent via certified mail.

15.

a. Except as otherwise provided in this section, the entire amount of any settlement of the recipient's action or claim involving third-party benefits, with or without suit, is subject to the

Medicaid payor's claim for reimbursement of the amount of medical assistance provided and any lien pursuant to the claim.

b. Insurance and other third-party benefits shall not contain any term or provision which purports to limit or exclude payment or the provision of benefits for an individual if the individual is eligible for, or a recipient of, medical assistance, and any such term or provision shall be void as against public policy.

16. In an action in tort against a third party in which the recipient is a party and which results in a judgment, award, or settlement from a third party, the amount recovered shall be distributed as follows:

a. After deduction of reasonable attorney fees, reasonably necessary legal expenses, and filing fees, there is a rebuttable presumption that all Medicaid payors shall collectively receive two-thirds of the remaining amount recovered or the total amount of medical assistance provided by the Medicaid payors, whichever is less. A party may rebut this presumption in accordance with subsection 17.

b. The remaining recovered amount shall be paid to the recipient.

c. If the recovered amount available for the repayment of medical assistance is insufficient to satisfy the competing claims of the Medicaid payors, each Medicaid payor shall be entitled to the Medicaid payor's respective pro rata share of the recovered amount that is available.

17.

a. A recipient or a recipient's agent who has notice or who has actual knowledge of the Medicaid payor's rights to third-party benefits under this section and who receives any third-party benefit or proceeds for a covered injury or illness shall on or before the sixtieth day after receipt of the proceeds pay the Medicaid payor the full amount of the third-party benefits, but not more than the total medical assistance provided by the Medicaid payor, or shall place the full amount of the third-party benefits in an interest-bearing trust account for the benefit of the Medicaid payor pending a determination of the Medicaid payor's rights to the benefits under this subsection.

b. If federal law limits the Medicaid payor to reimbursement from the recovered damages for medical expenses, a recipient may contest the amount designated as recovered damages for medical expenses payable to the Medicaid payor pursuant to the formula specified in subsection 16. In order to successfully rebut the formula specified in subsection 16, the recipient shall prove, by clear and convincing evidence, that the portion of the total recovery which should be allocated as medical expenses, including future medical expenses, is less than the amount calculated by the Medicaid payor pursuant to the formula specified in subsection 16. Alternatively, to successfully rebut the formula specified in subsection 16, the recipient shall prove, by clear and convincing evidence, that Medicaid provided a lesser amount of medical assistance than that asserted by the Medicaid payor. A settlement agreement that designates the amount of recovered damages for medical expenses is not clear and convincing evidence and is not sufficient to establish the recipient's burden of proof, unless the Medicaid payor is a party to the settlement agreement.

c. If the recipient or the recipient's agent filed a legal action to recover against the third party, the court in which such action was filed shall resolve any dispute concerning the amount owed to the Medicaid payor, and shall retain jurisdiction of the case to resolve the amount of the lien after the dismissal of the action.

d. If the recipient or the recipient's agent did not file a legal action, to resolve any dispute concerning the amount owed to the Medicaid payor, the recipient or the recipient's agent shall file a petition for declaratory judgment as permitted under rule of civil procedure 1.1101 on or before the one hundred twenty-first day after the date of payment of funds to the Medicaid payor or the date of placing the full amount of the third-party benefits in a trust account. Venue for all declaratory actions under this subsection shall lie in Polk county.

e. If a Medicaid payor and the recipient or the recipient's agent disagree as to whether a medical claim is related to a covered injury or illness, the Medicaid payor and the recipient or the recipient's agent shall attempt to work cooperatively to resolve the disagreement before seeking resolution by the court.

f. Each party shall pay the party's own attorney fees and costs for any legal action conducted under this subsection.

18. Notwithstanding any other provision of law to the contrary, when medical assistance is provided for a minor, any statute of limitation or repose applicable to an action or claim of a legally responsible relative for the minor's medical expenses is extended in favor of the legally responsible relative so that the legally responsible relative shall have one year from and after the attainment of the minor's majority within which to file a complaint, make a claim, or commence an action.

19. In recovering any payments in accordance with this section, the Medicaid payor may make appropriate settlements.

20. If a recipient or a recipient's agent submits via notice a request that the Medicaid payor provide an itemization of medical assistance paid for any covered injury or illness, the Medicaid payor shall provide the itemization on or before the sixty-fifth day following the day on which the Medicaid payor received the request. Failure to provide the itemization within the specified time shall not bar a Medicaid payor's recovery, unless the itemization response is delinquent for more than one hundred twenty days without justifiable cause. A Medicaid payor shall not be under any obligation to provide a final itemization until a reasonable period of time after the processing of payment in relation to the recipient's receipt of final medical services. A Medicaid payor shall not be under any obligation to respond to more than one itemization request in any one-hundred-twenty-day period. The notice required under this subsection means written notice sent via certified mail to the address listed on the department's internet site for a Medicaid payor's third-party liability contact. The notice requirement is only satisfied for the specific Medicaid payor upon receipt by the specific Medicaid payor's third-party liability contact of such written notice sent via certified mail.

21. The department may adopt rules to administer this section and applicable federal requirements.

History

C79, 81, § 249A.6; 83 Acts, ch 120, § 1; 83 Acts, ch 153, § 15; *89 Acts, ch 111, § 1*; *93 Acts, ch 180, § 50*; *94 Acts, ch 1023, § 89*; *2008 Acts, ch 1014, § 2*; *2009 Acts, ch 41, § 244*; *2009 Acts, ch 133, § 96*; *2013 Acts, ch 24, § 14*; C2014, § 249A.54; *2023 H.F. 685, § 2*, effective July 1, 2023.

LexisNexis® Iowa Annotated Statutes

Copyright © 2023 All rights reserved.

End of Document

MEMO
RE: Medicaid Subrogation Instructions

INSTRUCTIONS

The following instructions will provide a detailed list of what do you need to do, when, and how to be compliant with the new requirements of Iowa Code 249A.54.

The Department's Lien Recovery Webpage can be found at:
https://hhs.iowa.gov/ime/members/member-rights-and-responsibilities/tpl

1. The requirements under Iowa Code 249A.54 apply to new and pending cases.
2. You have 30 days to inform a Medicaid payor of any rights to third-party benefits your client may have, including the name and address of those liable. Iowa Code 249A.54(7).
3. You must give written notice to Medicaid Payors within 30 days of initiating recovery. Iowa Code 249A.54(11).
    a. This notice requirement applies to any recovery attempt whether formal or informal. Iowa Code 249A.54(11).
    b. Taking on a new client who is pursuing third party benefits may be considered initiating a recovery attempt. Iowa Code 249A.54(11).
        i. Must be through written notice (certified mail not required).
4. If an action is brought against the third party, you must provide written notice to the Medicaid payor within 30 days of filing. Iowa Code 249A.54(13)(4)(e).
    a. This must include the name of the court the action was filed in, the case number, and a copy of the pleadings. Iowa Code 249A.54(13)(4)(e).
    b. Filing the lawsuit, itself, does not constitute notice. 249A.54(13)(e).
5. One itemization request can be submitted to the Medicaid payor every 120 days. Iowa Code 249A.54(20).
    a. This itemization request must be sent via notice by certified mail to the Medicaid payor's address listed on the department's lien recovery webpage. Iowa Code 249A.54(20).
    b. A Medicaid payor's failure to respond within 65 days, without justifiable cause, may bar their recovery. Iowa Code 249A.54(20).
6. You must give the Medicaid payor an opportunity to recover by providing written notice of the proposed judgment, award, settlement, or recovery at least 30 days before finalizing a judgement, award, settlement, or other recovery. Iowa Code 249A.54(14).
    a. This written notice must be sent via certified mail to the Medicaid payor's address listed on the department's lien recovery webpage. Iowa Code 249A.54(14).
    b. The Medicaid payor has 30 days to respond. Iowa Code 249A.54(14).
    c. Failure to give proper notice leaves the recipient and their attorney jointly and severely liable to the Medicaid payor and risks the cancellation of Medicaid benefits. Iowa Code 249A.54(14).

d. Written notice must be provided to Medicaid payors 21 days before dismissal of an action. Iowa Code 249A.54(13)(4)(e).

   i. Must be through written notice (certified mail not required) and include the name of the court in which the action exists, the case number, and a copy of the pleadings. 249A.54(13)(4)(e).

7. In an action in tort against a third party, the recovered amount shall be distributed as follows:
   a. Reasonable attorney fees, reasonably necessary legal fees, and filing fees may be deducted first. Iowa Code 249A.54(16)(a).
   b. The Medicaid payor receives 2/3 remaining or the total amount of medical assistance provided (whichever is less). Iowa Code 249A.54(16)(a).
   c. The client shall receive what is remaining. Iowa Code 249A.54(16)(b).
8. You can dispute the presumption of the amount owed to the Medicaid payor. Iowa Code 249A.54(16)(a).
   a. To do so, you must put the full amount into an interest-bearing trust account for the benefit of the Medicaid payor within 60 days of receipt. Iowa Code 249A.54(17)(a).
   b. If an action must be filed disputing the reimbursement formula you have the burden of proving by clear and convincing evidence that the value is incorrect. Iowa Code 249A.54(17)(b).
   c. The proper court to settle disputes is the court where a recovery action was filed. Iowa Code 249A.54(17)(c).
   d. If no action was filed a petition for declaratory judgement must be filed within 120 days of receipt. The venue for declaratory actions is in Polk county. 249A.54(17)(d).

Refer to the chart that follows for quick reference regarding timelines and notice requirements.

Medicaid Subrogation Process
Updated 8/9/2023

The entire process by which we notify subrogation carriers for clients with Medicaid coverage (Molina; Amerigoup; Iowa Total Care; or Iowa Medicaid Fee for Service) has changed effective July 1, 2023. If we have any indication that the client was on Medicaid or has applied for Medicaid, we should follow this process.

The contact information for each MCO comes directly from the following website and these must be used as opposed to other contact information.

https://hhs.iowa.gov/ime/members/member-rights-and-responsibilities/tpl

This protocol should be followed for all cases currently open and those that are opened in the future.

1. When a case is opened, we have officially been retained, and we have contact information for the at-fault party, the at-fault insurance company, our client's motor vehicle insurance (if applicable), send Letter 1 via mail, email, and fax. Sending via email and fax can be done with one email I believe by putting the eGoldfax in as the primary address and then cc'ing the email address. Use the Clio outlook plugin to file to Clio.

   Deadline: 30 days after file open

2. Letter 2 is a request for subrogation itemization. We will no longer send these right away as a matter of course. We will rely on medical expense summaries. Once we are getting to about 60 days out from possibly settling, we will send letter 2. This is sent via email and fax but also by certified mail, return receipt.

   You may send these more frequently or at different intervals, but they are only required to provide 1 itemization every 120 days and they are allowed 60 days to respond.

3. Send letter 3 once we have reached a settlement agreement. This is sent via email and fax but also by certified mail, return receipt.

   Theoretically all settlements will be tentative until we hear back from Medicaid giving permission to settle and to accept our proposed payback. They have approximately 30 days to respond.

4. Send letter 4 if and when we file a lawsuit or WC petition. You must enclose a copy of the petition. This is sent via email and fax but also by certified mail, return receipt.

5. Send letter 5 if we are dismissing a lawsuit. We cannot dismiss a case without sending this notice and letting at least 30 days go by. The only needs to be sent via regular mail, email and fax.

Failure to follow these rules may result in our client's Medicaid being suspended and also the firm being held liable for the amount of reimbursement.

Timelines and Notice Requirements

Event	Time	Method of Notification	Miscellaneous
Notification of Benefits	30 days after being made aware	"Shall inform"; non-specific type or address 249A.54(7)	Rights to third-party benefits your client may have, including the name and address of those liable.
Initiating Recovery	30 days after filing	Must be through written notice; non-specific type or address 249A.54(11)	Formal or informal attempt
Notice of Filing	30 days after filing	Written notice that includes the name of the court the action was filed, case number, and a copy of the pleadings. Notice is specified by rule 249A.54(13)(e)	Filing the lawsuit, itself, does not constitute notice. What is the rule? Should be safe to send to the website address.
Itemization Request	1 request per 120 days	Certified mail to the Medicaid payor's address listed on the department's lien recovery webpage. 249A.54(20)	Medicaid has 65 days to respond.
Notice of Settlement	30 days before settling	Certified mail to the Medicaid payor's address listed on the department's lien recovery webpage. 249A.54(14)	Must provide the Medicaid payor a reasonable time to recover; Attorneys liable with their clients to reimburse Medicaid
Dismissal	21 days before dismissal	Must be through written notice that includes the name of the court the action was filed, case number. Notice is specified by rule 249A.54(13)(e)	Should be safe to send to the website address.
Receipt of any proceeds	Within 60 days of receipt of funds	Pay the Medicaid payor the full amount of their claimed lien or put in an interest-bearing account for MP 249A.54(16)(a)	Contradictory with other language re: trust account; also totally unworkable.
Dispute (Where Legal Action Was Filed)	Within 60 days of receipt	No specified action; file a motion or add the MCO 249A.54(16)(a)-(c)	The court where the action was filed retains jurisdiction.
Dispute (Where Legal Action Was Not Filed)	Within 120 days of receipt of funds or placing in trust account	File declaratory judgment. 249A.54(16)(d)	A petition for declaratory judgment must be filed in Polk County.; Must place in a trust account

[Date]

Sent via mail, fax, email to:
502-440-1100;
TRCCEN@rawlingscompany.com

Rawlings Company-Iowa Total Care
1 Eden Parkway
La Grange, KY 40031

RE: Notice pursuant to Iowa Code 249A.54(7) & 11

Client Name:	[Client name]
Plan:	[Health Plan]
Loss Date:	[Date of loss]
DOB:	[date of birth]
SSN:	[Social]

I am writing to inform you that my office has been retained to represent for injuries sustained on . My client has employed me to pursue any available third-party benefits.

By this letter you are noticed that there may be future rights to third-party benefits in the form of medical payments coverages or proceeds from an insurance settlement.

This is also notice of the initiation of recovery by my office on behalf of my client. The name and address of the potential third-party payors are:

1. Alleged at-fault party:
2. Alleged at-fault party insurer:
3. Client / Recipient first-party insurer:

Please direct all future communication, correspondence, or notices to my office via mail

[Date]

Sent via <u>certified</u> mail, fax, email to:
502-440-1100;
TRCCEN@rawlingscompany.com

Rawlings Company-Iowa Total Care
1 Eden Parkway
La Grange, KY 40031

RE: Request for itemization pursuant to Iowa Code 249A.54(20)

Client Name:	[Client name]
Plan:	[Health Plan]
Loss Date:	[Date of loss]
DOB:	[date of birth]
SSN:	[Social]

I am writing to request an itemization of medical assistance paid for any covered injury or illness for which you claim a reimbursement or subrogation interest relative to the aforementioned date of loss.

Pursuant to Iowa Code 249A.54(20) you are to provide the requested itemization within 65 days of your receipt of this request. Failure to provide the requested itemization within 120 days of your receipt of this request shall bar your recovery and my office will proceed without regard of your recovery interest.

Please direct all future communication, correspondence, or notices to my office via mail to

[Date]

Sent via certified mail, fax, email to:
502-440-1100;
TRCCEN@rawlingscompany.com

Rawlings Company-Iowa Total Care
1 Eden Parkway
La Grange, KY 40031

RE: Notice pursuant to Iowa Code 249A.54(14)

Client Name:	[Client name]
Plan:	[Health Plan]
Loss Date:	[Date of loss]
DOB:	[date of birth]
SSN:	[Social]

I am writing to inform you that my office has tentatively agreed to a judgment, award, settlement, or recovery where you claim the right to recovery.

The amount of the tentative settlement is $, inclusive of all damages.

We intend to finalize this judgment, award, settlement, or recovery on or after 35 days of the date of this letter.

Pursuant to your latest itemization provided, we intend to reimburse $ from the aforementioned settlement. If you object to any aspect of the aforementioned proposal, you must notify us immediately so that we may delay the disbursement while we work with you to resolve the dispute.

Please direct all future communication, correspondence, or notices to my office via mail to

[Date]

Sent via <u>certified</u> mail, fax, email to:
502-440-1100;
TRCCEN@rawlingscompany.com

Rawlings Company-Iowa Total Care
1 Eden Parkway
La Grange, KY 40031

RE: Notice pursuant to Iowa Code 249A.5413(e)

Client Name:	[Client name]
Plan:	[Health Plan]
Loss Date:	[Date of loss]
DOB:	[date of birth]
SSN:	[Social]

I am writing to inform you that my office has filed an action against a third-party who may be liable to pay third-party benefits covered under Iowa Code 249A.54. A copy of the action is attached.

Parties:
Court Name:
Case #:

Please direct all future communication, correspondence, or notices to my office via mail to

[Date]

Sent via mail, fax, email to:
502-440-1100;
TRCCEN@rawlingscompany.com

Rawlings Company-Iowa Total Care
1 Eden Parkway
La Grange, KY 40031

RE: Notice pursuant to Iowa Code 249A.54(13)(e)

Client Name:	[Client name]
Plan:	[Health Plan]
Loss Date:	[Date of loss]
DOB:	[date of birth]
SSN:	[Social]

I am writing to inform you that my office intends to dismiss the following action within 30 days of the date of this letter:

Parties:
Court Name:
Case #:

Please direct all future communication, correspondence, or notices to my office via mail to